Submitter : Lizbeth Abbott **Date:** 03/22/2005

Organization : Lizbeth Abbott

Category : Consumer Group

Issue Areas/Comments

ISSUE

Proposed Changes to LTCH PPS Rates and Policy for the 2006 LTCH PPS Rate Year

QuestionllWhen there are sssets either through the awarding of malpractice determination or life insurance, how do they affect Medicaid's responsibility to pay for medical services?

CMS-1483-P-2 **Prospective Payment System for Long-Term Care Hospitals FY 2006 : Annual Payment Rate Updates**

Submitter : Mr. Anthony Santangelo **Date & Time:** 03/29/2005

Organization : Partners Healthcare System

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1483-P-2-Attach-1.DOC

By Courier

March 28, 2005

Mark McClellan, M.D., Ph.D
Administrator
Centers of Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1483-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Dr. McClellan:

Partners HealthCare System, Inc. is pleased to comment on the Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates and Policy Changes, and Clarification, Proposed Rule, as published in the February 3, 2005 Federal Register, on behalf of its member Hospitals:

Institution	**Provider Number**
Shaughnessy-Kaplan Rehabilitation Hospital	222026
Spaulding Rehabilitation Hospital	222035

Proposed revision of LTCH-PPS geographic classification

Partners fully supports CMS' proposal to adopt the new definition of labor market areas according to Core-Based Statistical Areas (CBSAs), as it more precisely defines distinct labor market areas.

Currently, CMS reclassification policy allows qualifying counties to reclassify into a neighboring county whose wage index better reflects their labor costs. In cases where all the acute hospitals in a county are reclassified, we believe that the county's reclassified wage index should also apply to LTCHs (and, for that matter, all Medicare providers whose rates are adjusted using the acute hospital wage index) residing in that county because all of these providers compete with each other within the same labor markets.

I. Adjudication of claims under FISS

A. Overlapping claims

LTCH patients often receive ancillary services from the outpatient department of an acute hospital. When an acute hospital outpatient claim for an inpatient LTCH beneficiary is billed to Medicare, the FISS adjudicates the outpatient claim without checking if the beneficiary is an inpatient elsewhere. When the LTCH claim is finally submitted, it is erroneously denied due to duplicative date of service. We have been working with the fiscal intermediary to resolve this issue; however, the current intervention requires considerable manual effort.

We believe an automated solution is the most appropriate long-term solution. We are very cognizant, however, that any such solution must also address the administrative needs of the acute hospital (or other hospital) submitting the "first" bill. We therefore suggest the following: When an inpatient claim is submitted by the LTCH and conflicts with an outpatient claim in the same date of service range:

1. The inpatient claim is adjudicated and paid.
2. The outpatient provider is immediately notified of the date of service conflict, given the name and provider number of the LTCH (preferably electronically) and given a short period, say 10 days from notice by FI, to justify its claim. For example, there could be a 1-day error in the date of discharge on the inpatient claim, with the date of discharge being the 15th not the 16th. Therefore, the CT scan provided on the 15th (after discharge) is, in fact, a separately payable outpatient service.
3. Absent such justification, the FISS automatically cancels the outpatient claim and recoups payment.

B. Benefit Exhaust Cases

When a Medicare beneficiary is discharged from a LTCH to an acute hospital, the LTCH must hold the claim for 9 days before submitting it to the FI. If the beneficiary is discharged home from the acute hospital within the 9-day window, the acute hospital's claim can reach Medicare before LTCH. In cases where the beneficiary exhausts benefits and must therefore use lifetime days, this can create

the unfair situation whereby the acute care hospital, having billed first, utilizes the lifetime days even though its services were provided subsequent to the LTCH. Lifetime reserve days should be allocated based on the order of dates of service.

While there is currently an appeal mechanism in place for the LTCH to rectify this situation, this unfairly puts a considerable administrative burden on the hospital that rightfully should have been paid in the first place. Instead, we recommend that CMS implement an automated mechanism in FISS to flag and hold adjudication until the 12th day for acute hospital claims for beneficiaries who have exhausted benefits and have an admit source from a post-acute facility:

- If a claim is received from the post-acute facility within the 12 days, then adjudicate this claim first, including assignment of any necessary lifetime reserve days, and then adjudicate the acute hospital claim. Because the acute hospital claim has already been held, we believe it should not be subsequently subject to the 14-day claims hold in these cases.
- If the post-acute facility claim is not received within this time period, it will, in most cases, indicate that the patient has returned to the post-acute facility as an "interrupted stay". We will not suggest that the acute hospital claim be held until the patient is eventually discharged – however, there must be an expedited mechanism by which the LTCH can resolve any conflicts with the acute hospital regarding lifetime reserve days immediately after the patient is discharged from the LTCH. We would be happy to provide assistance to CMS in devising such a mechanism.

II. Benefit exhaust billing policy

In cases where the beneficiary exhausts benefits, providers must first bill Medicare to receive a benefit exhaust denial notice before billing the secondary payer. Prior to the implementation of LTCH PPS, providers were allowed to submit a claim every 30 days for benefit exhaust patients. Under PPS, the 30-day rule has been lengthened to 60 days, delaying billing of the secondary payer by 30 days, doubling the accounts receivable for these cases and creating an additional cash flow burden on some providers. We ask that CMS to revert back to its 30 days interim billing process.

III. FISS and administrative burden issues

Our providers work closely with the FI to resolve billing issues and smooth out administrative difficulties; however, there are issues that cannot be resolved without intervention from CMS, like those issues mentioned above. We strongly urge CMS to create a forum dedicated to the resolution of billing and administrative issues.

We appreciate the opportunity to comment on the proposed rule. Please contact me by phone (617 726-5449) or email (asantangelo@partners.org) should there be further questions.

Sincerely,

Anthony J. Santangelo, Jr.
Corporate Manager, Government Revenue
Partners HealthCare System
P.O. Box 9693
Boston, MA 02114-9693

Submitter : Mr. Anthony Santangelo **Date:** 03/29/2005

Organization : Partners Healthcare System

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1483-P-3-Attach-1.DOC

By Courier

March 28, 2005

Mark McClellan, M.D., Ph.D
Administrator
Centers of Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1483-P
7500 Security Boulevard
Baltimore, MD 21244-1850

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Anthony J. Santangelo, Jr.
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Partners HealthCare System
P.O. Box 9693
Boston, MA 02114-9693

Submitter : **Date: 03/29/2005**

Organization : **Kindred Healthcare**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1483-P-4-Attach-1.DOC

Kindred Healthcare

March 29, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
File Code: CMS-1483-P
Room 443-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Reference: 42 CFR Part 412
Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates and Policy Changes; Proposed Rule

Dear Administrator:

The purpose of this letter is to provide the Centers for Medicare and Medicaid Services (CMS) with Kindred Healthcare's comments and recommendations on the proposed annual payment rate updates and policy changes for long-term acute care hospitals (LTACHs). Kindred Healthcare is one of the nation's largest long-term acute care hospital (LTACH) providers, with 58 freestanding facilities, fourteen hospital within hospitals and 5,569 beds. In 2004, Kindred provided care to over 26,000 Medicare beneficiaries.

As a long-term acute care hospital company, Kindred provides specialized acute care for medically complex patients who are critically ill with multi-system complications and/or failures and require hospitalization averaging at least 25 days. Many of Kindred's patients—including Medicare beneficiaries—are admitted directly from short-stay hospital intensive care units with respiratory/ventilator-dependent conditions or other complex medical conditions. At Kindred's LTACHs, they receive a specialized treatment program with aggressive clinical and therapeutic intervention.

Kindred appreciates the consideration CMS put into developing these proposed policy changes. The following comments identify areas where we agree and support the proposed changes and CMS activities. The comments also discuss areas that may need additional consideration. As always, we look forward to working with CMS to develop a final rule that is reasonable and fair.

1. Monitoring

a. MedPAC Recommendations/RTI International Study

General Description. In the proposed rule, CMS stated it has hired a contractor to conduct an evaluation of recommendations regarding Medicare LTACH certification criteria made by MedPAC in a June 2004 Report to Congress. The Commission made two recommendations in the report:

- LTACHs should be defined by facility and patient criteria to ensure patients admitted to LTACHs are medically complex and have potential for improvement.

- QIOs should be required to review LTACH admissions for medical necessity and monitor LTACH compliance with defining criteria.

In response to MedPAC's June 2004 report, CMS has awarded a contract to Research Triangle Institute (RTI) International to evaluate the Commission's recommendations. The goal of the research is to document LTACH current practices related to the MedPAC recommendations in terms of provider certification, quality reviews, and hospital practices. The study will also examine the present role of QIOs by focusing on their responsibility regarding the LTCH PPS and the potential for an expanded QIO role as recommended by the Commission.

Assessment. Kindred strongly agrees with MedPAC's recommendations that certification criteria for LTACHs be developed and supports CMS' decision to conduct an evaluation of the LTACH provider community's practices and quality review programs. Kindred reviews each LTACH patient's medical conditions prior to admission and frequently throughout their stay to ensure only those patients needing highly specialized and intensive care services receive treatment in our hospitals. We believe all LTACHs should meet specific criteria to ensure they can provide the resource-intensive and specialized services LTACH patients need.

Kindred, in collaboration with others in the LTACH provider community, have already begun an evaluative study of the LTACH provider community with a focus on patient and facility level characteristics. This study builds on previous work we have done to identify criteria. This previous work has found that a set of LTACH certification criteria should be centered on three main categories:

- ***Patient Characteristics.*** LTACH criteria should encourage LTACHs to serve a medically complex patient population. The majority of LTACH patients should have multiple co-morbid conditions that complicate their primary diagnosis. There are two relevant proxies for measuring and monitoring this medical complexity:

- *Retain the current requirement for a 25 day average length of stay for Medicare beneficiaries.* The 25 day length of stay requirement is one reasonable proxy for medically complex care provided to patients who often need long hospital stays as part of their treatment; and

- *Create a new severity of illness threshold.* At least 50 percent of every hospital's Medicare discharges during its cost report year would be classified into either severity of illness level (SOI) three or four. The severity of illness level is based on the 3M APR-DRG classification system and would require that every facility use this grouper software to ensure that, over a year, at least half of their Medicare discharges are classified in SOI three or four.

- ***Structure.*** The second LTACH certification criterion should be aimed at ensuring that the LATCH is organized and operated to support the complex care required for its patients. Currently major LTACH providers are licensed as acute care hospitals, receive JCAHO accreditation, and meet CMS' hospital conditions of participation. While these quality monitoring mechanisms are important, more requirements are necessary to ensure that LTACHs have the capability to meet the unique needs of the medically complex LTACH patient population. Long-term acute care hospitals should have criteria that require LTACHs to have structural elements in place to deliver care (e.g., daily physician contacts, availability of respiratory therapy, and interdisciplinary team assessments).

- ***Admissions and Continued Stay.*** The third criterion for LTACH certification should ensure that admissions and continued stay standards are in place so that LTACHs serve the most medically complex patients. The implementing regulations for the new LTACH Prospective Payment System (PPS) direct the QIOs to perform greater oversight of LTACH utilization assessment and medical necessity review process (42 CFR412.508(a)). The certification criteria should specify that QIO review be based on a nationally uniform set of admissions and continuing stay criteria.

These criteria are very similar to those recommended by MedPAC. We hope to use the results from this study to contribute meaningful information and data to future policy discussions regarding LTACH certification criteria.

Recommendations. Kindred strongly supports the development of LTACH certification criteria using facility and patient characteristics. We believe research findings from the CMS/RTI International research study of the LTACH provider community will be a significant aid in developing new LTACH certification

criteria. Kindred requests that CMS consider the findings from our evaluation of LTACH provider community characteristics and practices in conjunction with the RTI study.

In the absence of a formal technical expert panel, CMS should require RTI International to work openly and collaboratively with the LTACH provider community in developing new certification criteria. Unlike inpatient hospitals or nursing facilities, there is little publicly available data providing information about LTACH patient outcomes and quality improvement activities. The LTACH provider community does have this data and RTI should work collaboratively with the community to obtain the best data possible. This is imperative for the successful development of certification criteria that reflect LTACH care. MedPAC has recognized this lack of publicly available LTACH data as well and acknowledges the need for close coordination with the LTACH provider community. A collaborative effort will provide the most accurate data and information about this provider group.

b. Quality Measures

General Discussion. CMS states in the proposed rule that it currently does not require LTACHs to submit any clinical or other quality data. CMS is considering what type of data, beyond current claims data, would be required for developing clinical quality measures for LTACHs and is presently evaluating whether CMS' Quality Measurement and Health Assessment Group should develop a quality measurement program for LTACHs. In the proposed rule, CMS stated quality measurement domains for LTACHs should reach a broad population, be based on medical evidence, be scientifically valid, and be actionable. In addition, CMS stated it would consider measures that cut across other care delivery sites and focus on areas such as medication management or patient safety.

Assessment. Kindred strongly supports CMS' proposal to develop a quality measurement program for LTACHs. Currently Kindred tracks the clinical outcomes of our patients to monitor the quality of care provided. Our program monitors ventilator-associated pneumonia, line-related blood stream infections, and acquired pressure wounds (see Table 1). We also track outcomes such as risk-adjusted ventilator wean rates and mortality rates (see Table 2). In addition to tracking clinical outcomes, Kindred also conducts patient satisfaction surveys which aid in quality improvement planning (see Table 3). Using this data we have established annual goals to improve clinical outcomes and quality of care for LTACH patients.

Table 1: Improved Quality Indicators
Hospital Division 2000 – June 2004

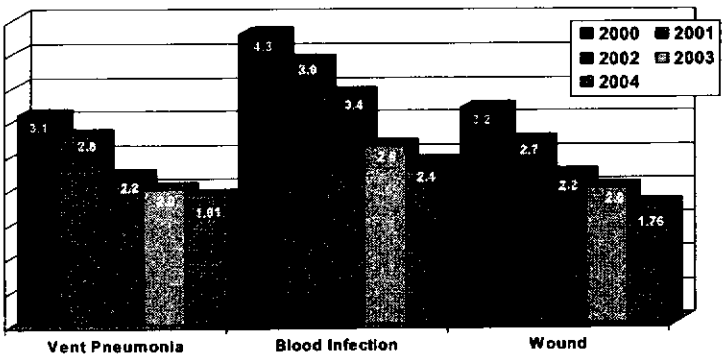


Table 2: Additional Quality Indicators

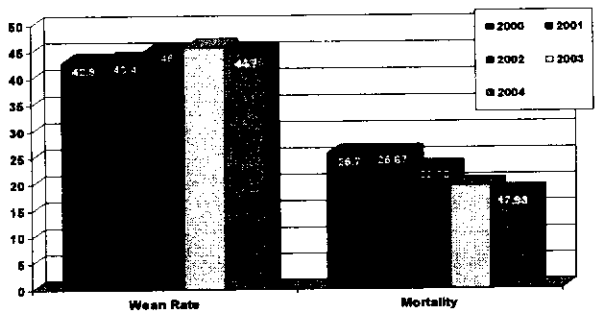
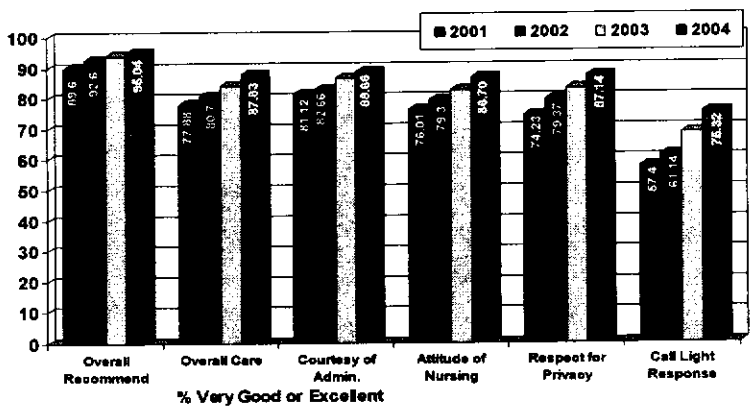


Table 3: Patient Satisfaction Measures



Recommendations. Kindred recommends that CMS proceed with the development of clinical quality measures for LTACHs. Kindred currently tracks and monitors LTACH quality of care using quality measures we have developed (Tables 1-3). We recommend CMS consider using quality indicators similar to those Kindred presently uses. We strongly encourage CMS to develop these measures in partnership with the LTACH provider community. We suggest an expert panel be formed to oversee and guide the development of quality measures for LTACHs. This panel should include physicians and other LTACH professionals, such as respiratory therapists. In addition, Kindred recommends CMS establish an LTACH specific quality initiative to employ these new quality measures. We encourage CMS to consider an initiative similar to the Hospital Quality Initiative where hospitals are given a financial incentive (0.4% higher annual payment update) for reporting quality measures. The development of an LTACH quality initiative should be done in cooperation with the LTACH provider community to ensure that measures are appropriately risk-adjusted and can be used to improve quality over time.

2. Monitoring LTACH Length of Stay

General Description. The proposed rule states that CMS is continuing to collect data on patients staying at LTACHs for periods of 6 months or longer. QIOs will evaluate whether such extensive stays may be indicative of LTACH patients who may be better served in skilled nursing facilities (SNFs). The proposed rule also restates CMS', MedPAC's, and other policymakers concerns with the rapid growth in the number of LTACHs and whether the appropriate patients are admitted and treated in these facilities. CMS also highlights a concern in the proposed rule with potential abuse of the short-stay outlier policy.

Assessment. Kindred supports CMS and QIO activity to monitor LTACH length of stay. Reigning in excessive stays when they are not medically necessary is important to maintaining the integrity of the provider category. In addition, we support monitoring of the short-stay outlier policy. However, we would like to emphasize several points related to this issue. First, while we agree with monitoring excessive lengths of stay, the role of the physician in determining an LTACH patient's course of treatment and their readiness to be discharged is paramount. Removing clinical decision-making from the hands of physicians could jeopardize patient care.

Second, CMS indicates in the rule that there may be incidents where LTACH patients stay in LTACHs for 6 months or longer and LTACHs hold patients who could have been discharged prior to the 5/6th geometric mean length of stay to

increase Medicare payments. We understand that excessive lengths of stay can raise costs for the Medicare program. However, as an experienced LTACH provider, we find that it can be difficult to find appropriate placement for LTACH patients in a SNF, with home health, or at home with their family. At times, there is no step-down provider available or family members are unwilling to discharge the LTACH patient. In these instances, the LTACH provider has no choice but to continue caring for the patient until appropriate placement is found.

In addition, Kindred believes it is critically important that treating physicians ultimately make the determination of when an LTACH patient can appropriately and safely be discharged to a step-down facility or home. The medical complexities of LTACH patients coupled with multiple interacting co-morbidities requires a physician's expertise to assess whether a patient is stable enough for treatment in a less acute setting.

Finally, our research shows that SNF care does not generally substitute for LTACH care. Kindred conducted an analysis in 2004 comparing the clinical characteristics of the Kindred Medicare SNF population with the overall national Medicare LTACH population using MedPAR 2001 data and Kindred SNF billing data.[1] The general findings of Kindred's SNF and industry-wide LTACH data analysis were that LTACH care does not generally substitute for SNF care:

- *There is little overlap in the most common primary diagnostic categories between LTACHs and SNFs.* The top ten most frequent APR-DRGs in each setting accounted for between 40 and 50 percent of all patients.[2] However, of the top ten APR-DRGs in LTACHs, there were six that did not appear on the Kindred SNF top ten list, and vice versa.

- *When primary diagnostic overlap occurs, major differences in severity of illness exist between patient populations.* Four APR-DRGs accounted for about 15 percent of total cases in each setting. When the 15 percent of patients in each setting were further classified according to severity of illness level, a much higher percentage of the LTACH patients in these four diagnostic categories were classified into the highest severity of illness (SOI) levels compared to Kindred SNF patients.

- *Overall severity of illness is significantly higher in LTACHs than in Kindred SNFs.* The severity of illness level for patients in each of the top 20 APR-DRGs treated at Kindred SNFs and LTACHs were statistically significantly different for 85 percent of these APR-DRGs.

Recommendations. Kindred supports CMS' efforts to collect data regarding patients who may stay in LTACHs for a significant period and we support the

[1] Kindred's SNF division is a large provider with over 250 skilled nursing facilities operating in over 30 states.

[2] This comparison used All Patient Refined-DRGs (APR-DRGs).

involvement of QIOs in evaluating such stays for medical necessity of patients. We also support monitoring of the short-stay outlier policy implications. Kindred recommends CMS look carefully at LTACHs ability to locate appropriate step-down care for patients who no longer meet LTACH level of care. We also recommend that if CMS makes changes to length of stay or short-stay outlier policies, the agency ensure physician decision-making remain intact and paramount during all phases of an LTACH patient's treatment.

3. Fixed-Loss Amount

General Description. In this 2006 payment update, CMS used cost-to-charge ratios (CCRs) from the Medicare Provider Specific File (PSF) to determine the estimated cost of each case. These costs are then used to estimate total Medicare payments under the LTCH PPS and set the fixed-loss amount. The proposed fixed-loss amount for 2006 is $11,544 and this will be used to determine whether a case reaches outlier status. CMS is using the new CCR from the PSF because they believe the CCRs are more recent than those from hospital cost report (HCRIS) files and there is more complete data for each LTACH in the PSF. The result is a much lower fixed-loss amount than 2005 ($17,864). CMS states that the previous two rate year fixed-loss amounts were sufficiently inflated to keep total outlier payments to less than 8 percent of total LTACH payments. Eight percent is the target amount of outlier payments CMS established when it implemented the LTCH PPS in October 2002.

Assessment. Kindred agrees with CMS' use of the PSF cost-to-charge ratios instead of older HCRIS data. We also would like to commend CMS for noting that total outlier payments in the 2004 and 2005 rate years were less than 8 percent of total Medicare LTACH payments. Using these updated CCRs will decrease the fixed-loss amount significantly and will help keep outlier payments at 8 percent of total LTCH PPS payments.

The fixed-loss amount ensures that LTACHs are paid for some of the additional costs associated with high cost cases. This is critical to ensuring that all LTACH patients, including those with significant care needs, receive the appropriate care. The fixed-loss amount helps LTACHs balance their own financial risk with providing the most appropriate care for Medicare beneficiaries. It ensures that very sick Medicare beneficiaries who need LTACH care are not discharged prematurely from LTACHs or are not admitted to LTACHs because of the risk they may pose an undue financial burden on an LTACH provider.

The 8 percent threshold was established to provide the most appropriate access to services for Medicare beneficiaries who need LTACH care. Setting total outlier payments at a threshold less than 8 percent would jeopardize some beneficiaries' ability to access care in LTACHs because fixed-loss amounts are set too high.

Using the best data available to determine an accurate fixed-loss amount is essential for maintaining access to appropriate and quality care for very sick Medicare beneficiaries needing LTACH care.

4. Medicare Payments

General Description. In this proposed rule, CMS estimates that total Medicare LTACH payments from 2006-2010 are less than those estimated in 2005 for these same years (Table 4). This revised estimate takes into account the increasing percentage of LTACHs that elected to be paid based on the LTCH PPS rather than a blend of the previous TEFRA cost-based system and the LTCH PPS. CMS currently estimates that 94 percent of LTCHs will elect to be paid under the LTCH PPS in 2006.

Table 4: Comparison of Estimates 2005-2006

LTCH PPS Rate Year	Estimated Payments ($ billions) 2006 Rate Year Proposed Rule	Estimated Payments ($ billions) 2005 Rate Year Final Rule
2006	2.94	2.98
2007	2.90	2.95
2008	2.96	3.01
2009	3.08	3.12
2010	3.24	N/A

Assessment. We note that this estimate and the previous year's estimate do not account for the recent policy changes that will affect LTACH hospital-within-hospitals. The August 2004 IPPS final rule established regulations that will require most hospital-within-hospitals to reduce the percent of non-outlier admissions they receive from their host hospital to 25 percent or less. This provision will be phased in over four years beginning in October 2005. As this change is implemented, it will have a significant effect on hospital-within-hospital providers who must change their business model to meet the thresholds imposed by the new regulation. It is likely many hospital-within-hospitals will take fewer Medicare patients with these new thresholds or choose to discontinue operating altogether. At a minimum, we expect fewer new LTACHs to seek Medicare certification.

Recommendation. Kindred believes the overall impact of these policy changes will be a reduction in LTACH Medicare spending. We recommend that CMS attempt to account for the impact of these changes in its estimates of total Medicare LTACH payments to ensure that policy-makers understand the impact of these recent changes.

5. Coding

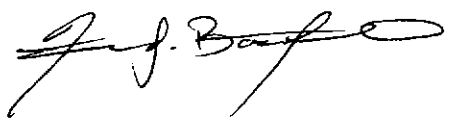
General Description. CMS emphasizes the importance of appropriate coding for LTACHs in this proposed rule. CMS has requested that the American Hospital Association (AHA) provide additional clarification on proper coding for LTACHs through its publication, "Coding Clinic for ICD-9-CM". This effort is in response to requests for additional clarification from LTACH providers. In addition, CMS has noted that the quality of documentation in actual LTACH medical records needs improvement.

Assessment. Kindred supports CMS' emphasis on the accuracy of coding. Reducing coding errors and improving accuracy will ultimately improve the validity of the LTACH payment system, ensuring the most appropriate payments are made to Medicare providers. Kindred is committed to accurate coding of all patient records and we support CMS' efforts to improve coding for LTACH providers. The company has established several built-in controls and systems to ensure coding accuracy. As a publicly-traded company, Kindred must meet the mandates and responsibilities of the Sarbanes-Oxley Act and report to its share-holders with the utmost financial accuracy. We have retained an external vendor to evaluate our coding accuracy because this drives our financial reporting as well as appropriate LTCH PPS payment policies. We will continue to support CMS in its efforts to monitor and improve this area and we remain committed to improving our accuracy as responsible corporate citizens and Medicare providers.

In summary, Kindred supports CMS' efforts to further define the Medicare LTACH provider category while ensuring medically complex beneficiaries get the care they need in the most appropriate setting. We encourage CMS and its contracts to work closely with the LTACH provider community as it evaluates potential certification criteria and a quality measurement program.

Thank you for your review of Kindred's comments. We appreciate your attention to the issues we have raised and look forward to working with you in the future.

Sincerely,



Frank Battafarano
President – Hospital Division

Submitter : Ms. Rochelle Archuleta **Date: 03/29/2005**

Organization : American Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1483-P-5-Attach-1.PDF

CMS-1483-P-5-Attach-2.PDF

American Hospital Association

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March 29, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS–1483–P
P.O. Box 8011
Baltimore, MD 20244-8011

RE: Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule [CMS-1483-P].

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,700 member hospitals and health care systems and 31,000 individual members, appreciates the opportunity to comment on the February 3, 2005 proposed rule concerning the long-term care hospital prospective payment system (LTCH PPS). The proposed rule contains the statutorily required annual payment update of 3.1 percent for the 2006 rate year, other policy changes, and a discussion of current and pending LTCH research.

Proposed LTCH PPS and Policy Changes

The AHA supports the proposed changes to the LTCH PPS, including the reduction of the fixed-loss amount for high-cost outliers, because they are based on data from the most recently filed cost reports. We also strongly support the proposal's call for a one-year extension of the exception to the three-day or less interrupted stay policy for surgical diagnostic related groups and urge the Centers for Medicare & Medicaid Services (CMS) to consider a permanent exemption for these types of cases. This would prevent LTCHs from having to cover costly surgical services for those patients who are transferred to general acute hospitals for three days or less to receive necessary surgical procedures beyond the medical scope of the LTCH.

As we did when the change was applied to general acute hospitals, we also support the transition from metropolitan statistical areas (MSAs) to core-based statistical areas (CBSAs) as the basis for creating LTCH labor market area definitions.

MedPAC Recommendations/Monitoring

The AHA applauds CMS for its efforts to build upon the June 2004 recommendations of the

Medicare Payment Advisory Commission (MedPAC) to develop patient and facility criteria for LTCHs to ensure medically appropriate admissions. Currently, this effort is being performed by CMS contractor Research Triangle Institute, International (RTI). Although the proposed rule indicates RTI will seek input from LTCHs to develop the criteria, we recommend that this step be solidified so that opportunities for exchange between CMS, RTI, and the field are explicitly added to the research plan. Other CMS contractors conducting research on significant new policy have successfully used this approach. For example, the Urban Institute conducted periodic meetings with a technical expert panel (TEP) to help develop recommendations for refining the skilled nursing facility PPS. Similarly, the RAND Corporation used a TEP to inform its research on the development and assessment of the inpatient rehabilitation facility PPS. TEPs have proven to be constructive and invaluable partners and would provide the same benefit to RTI as it works to develop LTCH patient and facility criteria. We, therefore, urge CMS to require RTI to establish a TEP to participate in the development of LTCH patient and facility criteria and to convene the panel on a regular basis to provide input on RTI's research scope, methodologies, and other relevant elements of the research plan.

Other

As the implementation date for the new payment adjustment for LTCH hospital within hospitals approaches, we again want to comment on its arbitrary nature and its limited ability to minimize overall growth of the LTCH field. Rather, this policy will limit appropriate medical access for certain patients because of the physical configuration of their referring hospital and LTCH even when the patient's clinical characteristics warrant LTCH care. We encourage CMS to instead focus on utilizing its quality improvement organizations (QIOs) and the pending facility and patient criteria to ensure that the appropriate patients are treated in LTCHs. The role of the QIOs in overseeing medical necessity in combination with the new criteria, have the potential to truly achieve CMS' goals without penalizing Medicare beneficiaries.

Thank you for the opportunity to comment on the proposed rule. If you have any questions, please contact Rochelle Archuleta, AHA's senior associate director of policy, at 202-626-2320 or via e-mail at: rarchuleta@aha.org .

Sincerely,

Rick Pollack

Rick Pollack
Executive Vice President

Submitter : Claude Ritman **Date:** 03/29/2005

Organization : Coler Goldwater Specialty Hospistal & Nursing Faci

Category : Hospital

Issue Areas/Comments

GENERAL

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See attachment.

CMS-1483-P-6-Attach-1.PDF

COLER ♥ GOLDWATER

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CLAUDE RITMAN
Executive Director

March 29, 2005

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Department of Health & Human Services
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SUBJECT: COMMENTS ON PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM CARE HOSPITALS: PROPOSED ANNUAL PAYMENT RATE UPDATES AND POLICY CHANGES

Dear Dr. McClellan:

Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater") is pleased to present the following comments on the Centers for Medicare & Medicaid Services ("CMS") proposed rule on the Prospective Payment System for Long-Term Care Hospitals (LTCH-PPS): Proposed Annual Payment Rate Updates and Policy Changes that was the subject of a notice of proposed rulemaking ("NPRM") that appeared in the *Federal Register* on February 3, 2005, at 70 *Fed. Reg.* 5724.

With regard to the MedPAC Recommendations/Monitoring, Coler-Goldwater is concerned about how CMS plans to develop criteria for appropriate admissions and how it plans to gather data to better understand the factors contributing to extremely lengthy stays, as well as very brief stays. Coler-Goldwater believes that it is imperative that CMS first include the LTCH industry in this process. The input of facilities and organizations which represent LTCH's, such as the NALTH, must play a key role in order to make this process truly collaborative. Coler-Goldwater strongly believes that only by including the stakeholders can the process undertaken by CMS be assured of developing definitions and industry standards that ensure quality services in a cost-efficient manner, which meet the needs of the communities and populations served.

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Coler-Goldwater also believes that there is a *geographic diversity* among LTCH's, based upon the continuum of care resources available in a given area of the Country. New York City, because of is vast size and diverse patient population, has distinctly different continuum of care needs that would be found in a rural area in the south. We believe that such differences largely account for the variations in the length of stay among LTCH's. We are thus opposed to any attempt to develop a narrow definition for LTCH's, based upon a so called "LTCH Prototype", which does not truly exist. In order to truly comprehend the variations in lengths of stay among LTCH's, such an undertaking must also look at all of the external contributory factors in the different areas of the country, which influence this process. By merely focusing upon LTCH specific internal data, such a process cannot reach accurate conclusions.

Another major concern we have is that the MedPAC Recommendations/Monitoring does not examine the role of Nursing Facilities, many of which attempt to provide a level of service far above their intended role and capabilities in continuum of care. Many such Nursing Facilities attempt to provide a level of service which might appear to overlap with LTCH's. We question whether they, indeed, provide the same level of care and quality provided by LTCH's such as Coler-Goldwater. We believe that LTCH's provide a much higher level of quality care, and are more cost-effective than such specialized NF's, when one takes into account complication rates, readmission to acute hospitals, as well as intervening lengths of stay in acute care hospitals for such patients.

In conclusion, we believe that the Quality Improvement Organizations continue to be the entity best suited to resolve questions pertaining to the appropriateness of admission, rather than some imposed CMS inflexible set of guidelines, which may not apply to the given situation. Coler-Goldwater, thus, would like to work with CMS, in a meaningful way, in an attempt to develop new standards for admissions and continued stays in LTCH's, which are fair, flexible and take into account the *geographic diversity* among LTCH's.

Sincerely yours,

Claude Ritman

CR:j